THE FAMILY IN THERAPEUTIC DESIGN OF USERS OF CAPS: REPRESENTATIONS OF HEALTH PROFESSIONALS

A FAMILIA NO DESENO TERAPÊUTICO DOS USUÁRIOS DOS CAPS: REPRESENTAÇÕES DOS PROFISSIONAIS DE SAÚDE

LA FAMILIA EN EL DISEÑO TERAPÉUTICO DE LOS USUARIOS DE LOS CAPS: REPRESENTACIONES DE PROFESIONALES DE LA SALUD

Norma Faustina Rocha Randemark1, Sônia Barros2

ABSTRACT

Objective: apprehending the representations of the professionals of the CAPS about the families and their inclusion in the design of therapeutic services users. Method: a qualitative study with semi-structured interviews whose findings were submitted to discourse analysis and grouped into categories and subcategories. The study had the research project approved by the Research Ethics Committee, Protocol 0272/06. Results: confirm the importance of the inclusion of families in therapeutic design of users of CAPS, emphasize the fragility at the expense of their therapeutic potential, suggest that the difficulties of the service to promoting the strengthening of the link and partnership with families. Conclusion: it was highlighted the need to contemplate the specificities of the families, the greater commitment of the Government in the provision of resources, network of joint attention in mental health to promote the role of the family and building new social spaces carrier validation of mental disorder. Descriptors: Mental Disorder; Family; Psychosocial Rehabilitation; Everyday Life.

RESUMO

Objetivo: apreender as representações dos profissionais dos CAPS acerca das famílias e inclusão delas no desenho terapêutico dos usuários dos serviços. Método: estudo qualitativo com entrevistas semiestruturadas cujos achados foram submetidos à Análise do Discurso e agrupados em categorias e subcategorias. O estudo teve aprovado o projeto de pesquisa pelo Comitê de Ética em Pesquisa, protocolo 0272/06. Resultados: confirmam a importância da inclusão das famílias no projeto terapêutico dos usuários dos CAPS, enfatizam a fragilidade em detrimento do seu potencial terapêutico, evidenciam que as dificuldades do serviço para promover o fortalecimento do vínculo e parceria com as famílias. Conclusão: evidenciou a necessidade de contemplar as especificidades das famílias, maior compromisso do poder público na provisão de recursos, articulação da rede de atenção em saúde mental para promover o protagonismo da família e construção de novos espaços de sociais de validação do portador de transtorno mental. Descriptores: Transtorno Mental; Família; Reabilitação Psicossocial; Cotidiano.

RESUMEN

Objetivo: aprehender las representaciones de los profesionales de los CAPS de las familias y su inclusión en el diseño de los usuarios de servicios terapéuticos. Método: estudio cualitativo con entrevistas semiestructuradas cuyos resultados fueron sometidos a análisis del discurso y agrupados en categorías y subcategorías. El estudio había aprobado el proyecto de investigación por la Comisión de ética de investigación, protocolo 0272/06. Resultados: confirman la importancia de la inclusión de las familias en diseño terapéutico de los usuarios del CAPS, enfatizan la fragilidad a expensas de su potencial terapéutico, sugieren que las dificultades del servicio para promover el fortalecimiento del vínculo y colaboración con las familias. Conclusión: destacó la necesidad de contemplar las especificidades de las familias, el mayor compromiso del gobierno en la provisión de recursos, red de atención conjunta en salud mental para promover el papel de la familia y construir nuevos espacios sociales de validación del portador de trastorno mental. Descriptores: Trastorno Mental; Familia; Rehabilitación Psicosocial; Todos los Días.

1Nurse and Psychologist, Professor of Nursing, Nursing Course, State University of Ceará/Uece. Fortaleza (CE), Brasil. Email: nrandemark@hotmail.com; 2Nurse, Doctorate in Nursing, Free Docent, Principal Professor, Department of Mother and Child and Psychiatric Nursing, Nursing School, University of São Paulo /EEUSP. São Paulo (SP), Brasil. Email: sobarros@usp.br
Singular therapeutic project is the term used to denote a set of articulated therapeutic strategies involving mental patients, their family and social network, the result of discussions and collective construction of an interdisciplinairy team, dedicated to meeting the needs of production autonomy, leadership and social inclusion of users of mental health service.1

In the Centers for Psychosocial Care (CAPS), the treatment plan is based on the concept of extended clinic, whose main characteristic is to articulate the basic health network and develop care strategies those emphasize both biological and organic dimension of disease and the risk of becoming ill as those related to subjective and social risks. Therefore, these services attention are focused, among other things, on the acceptance and bond between workers and users, and emphasizes the role of the family and its partnership with health professionals to accountability of care.2 Another advantage of the therapeutic project focusing on extended clinics concerns to the adoption of strategies to the attention of natural demands of the subject of care.

Indeed, the proposal to perform actions changing the focus of the individual subject to the singular, unlike what happens in diagnostic procedures that tend to equate these subjects and minimize their differences, enables the adoption of difference as a central element of articulation, emphasizing the health-disease process, the role of other actors in the social and family network of the user.3 Through this perspective, the project will more effectively the greater its ability to include the user in its uniqueness and coordinating with the network of family and social support, allowing the construction of links to the services so that they can carry out actions of a preventive nature and health promotion in the territory.

It should be noted, still, that compared to other mental health assistance equipment the main peculiarity of the CAPS in the production process of care consists in the fact that their strategies don't reduce the increase of skills or reduction of disability of the subjects, but seek to promote trading relations and autonomy, enlarge the rehabilitation scenarios and convert the change agent team able to intervene in family disputes and territorial by improving the quality of life and promoting social inclusion.4

It should be remembered that, at the 2nd National Conference on Mental Health, the inclusion of family in treatment plan of CAPS has become one of the prime aspects of official speeches.5 Since then, the family came to be seen as a potential therapeutic system, by occupying a strategic position close to the patient, it should play the process of social inclusion in the user community, the social control of health, combating prejudice and promoting autonomy and citizenship, helping to improve the quality of life of the person with mental disorders. Corroborating with this assertivate a study aimed at identifying the mental health actions developed in CAPS directed to the family in care of sick relatives found that working in CAPS only materializes family partnership and participation since the bond of families with services is essential to combat stigma and minimize the suffering of living with the disorder mental.6

Despite the recognized importance of mental care by the family, it is necessary for the mental health services taking into account the overhead that this task entails to caregivers and their effects on the care provided by family, so that studies warn of the effects of stressors on those who care for a sick person in the family, referred to as care overload.

By overload of care comprises a complex structure whose definition is quite broad and has criticized generally negative connotation being frequently defined by their impacts and consequences on caregivers. The initial conceptualization of overload of care has two distinct components, namely: the objective component that seeks to indicate their effects on the family, how to take care of daily tasks, and the subjective that indicates the level to which carers understand the burden of care. He adds that in addition to the physical and economic impact, emotional, psychological concept involves subtle notions, too, but annoying, such as shame and guilt. To achieve a balance between the patients and caregivers in the process of care, the latter should also be included in the plan of care and information and support tailored to their needs.7

Under the substitute services, the difficulties to consolidate the proposal on including the family in the treatment plans of CAPS are associated with prejudice in social and family environment, lack of families on the mechanisms of social participation as a means of social inclusion and expansion citizenship rights of the user, in addition to the emotional stress and negative feelings to the experience of family members with mental disorder, conditions that contribute to
non-adherence to treatment and activities offered by service, strengthening hospital-centered culture and limiting the role of the family in the process of care of mental patients disorder.8–10

The reality explained about the questions raised dimensions of the work process of the professionals of the CAPS, giving rise to the following guiding questions: What conceptions of health professionals about the families of people with mental disorders? Which are the instruments adopted in the everyday work of the CAPS? How these instruments contribute to promoting the inclusion of families in therapeutic design of users of these services.

**OBJECTIVE**

- Apprehending the representations of professionals of the CAPS about the families and their inclusion in the therapeutic design of users of these services.

**METHOD**

This is an exploratory descriptive study with a qualitative approach, whose findings were extracted from the field research for the Doctorate thesis entitled: Psychosocial Rehabilitation of persons with mental disorder in the context of the Brazilian psychiatric reform: representations of families (EEUSP/2009).

The subjects were health professionals crowded top-level us CAPS, totaling four managers and four family groups coordinators. The subjects have been identified by the letter G or C, followed by the unit number (F) selected for illustration. All signed an informed consent, in compliance with the resolution n° 196/96 of the NHC. The study obtained the approval of the Ethics Committee of the Board of Health of São Paulo as a project of the CAAE No. 0272/06, ratified through the opinion No. 0034/07.

The scenarios were 01 CAPS for regional health, located in the city of São Paulo/SP, totaling 05 services. The collection of findings was held by semi-structured interview. The lines of respondents were recorded, transcribed in full and submitted to discourse analysis.

The discourse analysis is a method that conceives the language as social institution and ideology vehicle needed for mediation between man and his natural and social reality, and aims to demonstrate how language produces meaning for man, influencing the way you think and act.13

The treatment of the findings included the attentive reading and repeated throughout the text in order to correct distortions and focus on figures and themes. The themes and its sub-themes were grouped into a category: the process of empirical Work of health professionals the Psychosocial Attention Center: analysis, based on relevant literature, took place through social and historical contextualization, critical eye and textual reconstruction of the beliefs, conceptions and values inserted in the speech, underscoring its contradictory aspects.14

**RESULTS AND DISCUSSION**

- The process of work of health professionals of psychosocial care centers (CAPS)
  - Conceptions of the Object-Family:

  The conceptions that professionals about the object of the work process are fundamental in the organization of health care.

  It is worth clarifying that the three dimensions of the work process in health include: Object / Subject, which is the definition of who or what is directed the care; Means and instruments that consist knowledge, methods, techniques, equipment and or / resources used to perform the work and Homes, defining what you want to achieve with the work.15

  Taking care of the family as an object is apprehended through the speeches that families are characterized as affective and economically deprived and struggling to care for a relative with mental disorder because they demonstrate anxiety and face the difficulties expressing feelings of guilt.

  C2F22 - Are families very, affectively and economically, needy.
  G2F20 - I think the families have a lot of anxiety, a lot of guilt and many difficulties in dealing, right?

  The professionals consider that these feelings are triggered not only by the difficulties of family members in dealing with the mentally ill, but also for their unrealistic expectations facing the real possibilities of “becoming” of the familiar sick and by the non-recognition of their existing limitations before falling ill, compounded by the irritation crisis, as expressed in the speech:

  G3F24 - This boy has certain limitations.
  The mother who has a son who has limitations as a kid understand that, but a mother who has a wonderful son who is the pupil of the eyes of this MOM that I do not get along with her husband, who has a silver lining. The project's own family was that boy. This boy (…), all of a sudden, they call from work, he studied at night and work

Randemark NFR, Barros S.
during the day, saying: ‘Your son is very weird, screaming, giving punched in the wall. Get there and he’s a psychotic break, which can be fleeting, can be chronic (...) and then, it is difficult for the family.

Worth pointing out that the emergence of mental illness in one of its members puts the family group face to face with the unknown, so that the search for understanding of the disease is characterized by the idea of unpredictability of the patient’s behavior and attempts to reconstruct the missing link capable of uniting cause and effect, mostly based on organicistas and psychodynamic concepts that, by assigning the responsibility for production of the sick psychic, spark feelings of guilt that limit their role in the care of a relative with mental disorder.

That speech pointing fault contributed to reproduction thrived ministerially centuries of knowledge and practices of social exclusion in the hospice, moving the family out of the context of treatment.

In the speech of the respondents, among the main feelings present in family members were appointed: fear, apprehension and guilt. C4F11 - Sometimes, they get very scared, huh? Are relatives of people who have had a recent crisis, then, are even starting to get involved with this issue, then arrive very apprehensive and have many problems, so you want to know a lot, sometimes, what started it? So, have a lot of guilt. So, it's working, right? The feelings of guilt.

C2F28 - (...) because it starts getting delusional, is part of the frame that offers risk to the family.

Other attributes that involve the characterization of families by the professionals of the CAPS are "(de) individualization" and demotivation. It took the term "(de) individualization" to set the trend that has the familiar to annul their singularity and author-represent based solely in the role of carer next to relative with mental disorder.

C4F14 - In General, they speak thus: I am mother of guy, I'm a mother of (...) even speak its name and then you question: But what is your name?

It is important noting that the trend of the family to divest itself is evidence of a daily life marked by resignations to personal projects, concerns, financial and emotional overload, where there is little time to care and think about yourself or engage in rewarding activities which can produce feelings of self-fulfillment.

The above pathological bond, called codependency, is defined as a psychological, emotional and behavioral condition associated with an unhealthy dependency and other compulsive concerns to control it to meet the emotional needs, leading often leads to dysfunctional interpersonal relationships. 17

This type of relationships upon which culminates in severe distress is severe limitations in generating life of the caregiver and care subject has been identified by CAPS professionals that link the need to include these services, strategies for promoting improved quality of lives of family caregivers:

The pathological link described above, named codependence, is defined as a psychological condition, emotional and behavior associated with an unhealthy dependence on the other and whether mandatory concerns to control it to satisfy the emotional needs, leading often to dysfunctional interpersonal relationships. 17

This kind of relationship link that culminates in intense suffering and severe limitations on the generator's life of the caregiver and the subject care has been identified by the professionals of the CAPS that point the need to contemplate in these services, strategies to promote the improvement of the quality of life of family caregivers:

C4F11 - We've been seeing in these groups was also very important to take care of these people, these caregivers, because, in General, they are facing the problem of the son, of the familiar, huh? Thus, they are very experienced. They are very well, without moments for them, unmotivated. Their lives are all very loaded.

● Instruments of intervention in Health Care to Families of Users of CAPS:

In this section, it was sought to identify the instruments the CAPS covering the participation of family and seize their purposes. According to the interviewees, these instruments consist of internal activities aimed exclusively for family members seeking the provision of emotional care and support management of situations, that comprise the therapeutic groups and guidance group multifamily, and activities of external attention towards the development of sociability, social control, culture, leisure and social inclusion, such as: cultural and festive events and the domiciliary visit, the latter including the participation of the user.

GE1-F42 - The activity covering families are family groups, home visits and activities of social integration, as the cup of inclusion.

CE1F3 - Designed specifically for families are the only therapeutic groups.

Regarding the therapeutic groups of families, respondents indicate some
contributions which enhance its importance for the therapeutic project from the user, they are:

- Strengthening the link between family and CAPS and establishing a partnership of the same with the CAPS by team awareness about the needs of families.

G1F14 - (...) be able to sensitize these family settings for a partnership with the CAPS on treatment management, participating in, supporting the therapeutic projects, right?

- Providing guidelines on the disease, patient management, drug treatment and prevention of crises.

- Identifying the psychoemotional needs of family, support emotional care, intervene in family disputes and refer them to services that support psychotherapy.

C3F6 - So, basically, it's an explanation that is given along the participation of him, isn't it? With reports that all family members of the group; they manage to bring that this behavior is due to the disease.

G2F21 - I think they benefit in this sense of being able to think, to be able to see how they participate in it. They are always involved, right?

G3F29 - In addition to the drug issue, this issue of organic medical orientation psychopharmacological is very important!

G3F29 - We try to avoid having another outbreak that has some care with medication, sleep, does not require more than he can, not to expose this patient's situations that he cannot answer.

- Serve as a space of support and exchange of experiences.

G2F23 - We try, in the family, family care, work, psychological issues but if we realize that can't handle, being necessary a family service, us forwards.

C1F3 - This group aims, therefore, is an area of support, right? Because the families arrive eager, without understanding very what occurs. Then, we give support and also the exchange of experience and also the difficulties those often get just under familiar can be brought to the Group and can be worked, certainly.

- Promoting the patient's acceptance by the family as strategy for psychosocial rehabilitation.

C4F22 - (...) is that in general, people understand the speech of them too so to generalize: no, it's because they are so they are baked, right? Put in a bag, right? And depersonalizes, right? So, to see how it is with your son, right? What's it like when he's having a crisis? How does he get before this crisis or what stress more? (...) Start distinguishes. This is very important!

With regard to outside activities, respondents indicate social inclusion actions that aim to expand the civil participation, enlarge the network of solidarity, promote the socialization of families and contribute to the validation of the social and family users, as illustrated by excerpts from the speech:

G2F33-Here in the neighborhood has many programs to the public, to the population, we think you might be able to enlarge the civil participation. And that there is a field that people can attend without necessarily having to have money, okay? A field of socialization that's what the people want.

G2F50-It is very important that the patient is position because the patient is in a position to whom the party program and then offers to the families. This position is a position of validation.

The home visit, in turn, is an activity carried out by foreign team members weekly whose actions include both families as users with the following purposes:

- Performing the active search.

G1F37 - (...) look, first to treatment adhesion. If the guy is not coming, we're going to see what's going on, we call that an active search.

- Recognizing the family psychodynamics.

C1F20 - O objetivo é sensibilizar e perceber também como é o convívio familiar, porque você indo “in lócus”, você consegue perceber, né? Algumas coisas que não aparecem nos grupos, nos atendimentos (...)...

- Working the adhesion of the patient to the treatment.

C1F21 (...) also, patient awareness. Sometimes, he doesn't want to take the medication, he don't want to come to the treatment groups.

- Establish contact and combat strength of the family to engage in therapeutic design.

C2F21-When there is a need we do home visits where we try. If the family does not come at all, we go to the family. One of them is when the family refuses to come and we need to know what's going on. Other times, it's a patient impossibility, he disappears.

- Medicalize the most difficult cases.

C2F50-the case that I went up to him (doctor), the patient doesn't leave home for more than eight years; had no social contact with anyone but his mother. He only began to be very disorganized, was no longer asleep, although he stayed the whole time locked at home, without contact with
Randemark NFR, Barros S.

The family in therapeutic design of users...

G3F20-They have some prejudices, in fact, with in relation to the psychic sick.

G2F62-there are some families that have a social level, has been a lot of people of the middle class, but many middle-class families don't want to attend this group. Is this issue, an activity of social prejudice that has to be broken.

✓ Emotional overload and ignorance of the therapeutic potential.

G2F60-I'm saying that when we do, there is no membership. There are many reasons why doesn't exist. Because the family, generally, when it comes here she went through situations very extensive, very, very tiring, very serious. So, they want a rest. Then, they face a little the day to day patient here as a way to do a power reset.

G3F19-Find that the family cannot do anything for them (...) or too, there's a lot that they could be doing more (...). They can do a lot. There's a lot of stuff. They are unaware of.

Regarding the institutional conditions that hinder the accession of relatives to the therapeutic project CAPS were singled out by respondents: the absence of State support, absence of update program, lack of articulation the network in the territory, precariousness of resources, lack of interest from professionals, customers demand greater operational capacity, lack of services and professionalsConsequently, lack of availability of professionals to develop a differentiated work and offer diverse activities, capable of awakening the interest of the families.

G1F18-(...) the State offers nothing, there is no upgrade program, we don't have permanent education supervision and people don't seek individually.

G2F42-(...) they are weakened also because it lacks a reference network and because the CAPS, for lack of network, end up answering those who should be met in UBS. C2F62-we could be doing more interesting encounters, with dynamic, with a larger involvement so that they feel a concern, because we have concern, just as often, we can't pass them this work to engage even more.

By excerpts of the speeches you can identify that the reflexes of the difficulties described above focus both in the articulation of work teams and team relationship with families, limiting their therapeutic potential and the role of the family in the process health disease.

G2F45-So, the teams are much unorganized. Very well, let's just say down and small. In fact, they can't articulate a project that...
actually makes sense to the own team. I'm sure, absolutely sure, that for all mental health teams of CAPS makes sense to work with the family and they are disarticulated to do this.

G3F39-The own professionals also have difficulties of relativization of your questions and the type of care because, due to the lack of conditions in the service. It's easier for you to meet objetalmente, so that this relationship is kind of crystallized.

Challenges for the inclusion of families in Therapeutic Design of CAPS users:

Regarding the effective participation of families in treatment plans, the CAPS manual establishes a partnership with the family by encouraging direct participation in service activities, placing them in work projects and community action for social integration, meetings and assembléias. 18

In this study we seized the care planning user in CAPS is given by preparing the treatment plan and provides for the inclusion of the family in the care process to enable it to provide support in crisis, avoiding thus the hospital admission. However, there is no consensus among professionals about the inclusion of families, once we find services that influence this decision to the users' permission, as identified in the following narrative:

G1F16(...) it is important to include it in the therapeutic project because in times of disorganization, is this family that will have to be non-committal, will afford the unrest.

C3F2-in fact, every patient who comes in here, we do a therapeutic project. In this project, as we delivered basically adults, if the patient allows, we try to include the participation of the family, since the patient permits, there are some who do not want the participation of family.

On some surveyed services, although the professionals recognize the importance of including the family in therapeutic design, as the focus is work with the patient, it is observed that actions geared toward the specific needs of the family, although available, are restricted.

C1F1-Nothing is separate. She is included in the patient's therapeutic project.

G139-actually, we don't have a therapeutic project family, meet the family is part of the patient's therapeutic project.

C2F39-when the family gives a holder with all that guidance, the evolution is faster, interesting that there, too, is not the economic issue, social. I think what weighs is her interest, recognition for his sick family, a bond.

In the clash of the relationship with the mentally ill can emerge needs requiring interventions able to benefit the family as a whole group, as illustrated in the following speech, when one of the managers signals the need to contemplate in terms of service goals of therapeutic design strategies to promote the well-being of the family group, considering the specificities of each family.

G1F40(...) but, perhaps, we (...) it would be interesting to us (...) we had goals to be achieved with each family.

About the planning of the family inclusion in therapeutic design of patient stands out as one of the biggest challenges the need to take into consideration not only social, economic specificities of these families but also the affective and cultural in determining the motivations of the same for the care of relatives diseased.

FINAL REMARKS

The research, although confirming the importance of the inclusion of families in therapeutic design of CAPS, showed that health professionals still emphasize the frailties of the family at the expense of their therapeutic potential. With regard to the strengthening of ties and establishment of partnership with families did note that the difficulties to implement the strategies are not restricted to the scope of the services. As a challenge to professionals of the CAPS, highlighted the need to consolidate a clinic able to overcome the walls of the institution and of greater commitment of the Government and of other segments of society in the provision of resources and coordination of mental health care network in order to promote the role of the family in the construction of new perspectives on madness and of new social spaces of validation subject bearer of mental disorder.

ACKNOWLEDGEMENTS

To the Coordination for the Personnel Improvement of Higher Education - CAPES.

REFERENCES


2. Mângia EF, Castilho JPLV, Duarte VRE. A construção de projetos terapêuticos: visão de profissionais em dois Centros de Atenção


The family in therapeutic design of users...